

FILED FEB 24 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 278

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 144

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME William J. Frein

3. (b) If veteran, _____ 3. (c) Social Security
name war. _____ No. No

4. Sex Male 5. Color or
race White 6. (a) Single, widowed, married,
2 divorced Widower
(b) Name of husband or wife _____ 6. (c) Age of husband or wife if
Julia Frein alive ? years
7. Birth date of deceased December 9th, 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 0 25 _____ hr. _____ min.

9. Birthplace St. Louis Mo D
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor & Builder

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Frein
13. Birthplace Waterloo Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Rossieur
15. Birthplace Alsace Lorraine 5
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph P. Frein
(b) Address #11 Rosemont Webster Groves Mo.

17. (a) Burial (b) Date thereof 1/6/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address 6633 Clayton Road

19. (a) JAN 6 1942 (b) J. J. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 4 9
(If outside city or town limits, write "RURAL")
(d) Street No. 6541 Clayton Ave
(If rural, give location)
(e) Citizen of foreign country? () (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 4th,
year 1942 hour 2 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from
12/24/41 19____ to 1/4/42 19____
that I last saw him alive on 1/4/42 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Chronic interstitial nephritis 5 yrs
Pneumonia 2 days

Due to Arteriosclerosis 10 yrs

Due to Senile Dementia 2 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature Ralph E. Gaston (M. D. or other)
Address #17 East Lockwood Date signed 1/5/42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.